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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARTHA L. DEMEYERE, RN** **8480 Travis Court** **San Diego, CA 92126** **Registered Nurse License No. 423406** Respondent.	Case No. 2010-6 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about April 30, 1988, the Board of Registered Nursing issued Registered Nurse License Number 423406 to Martha L. Demeyere (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

10. Patient D.D., a 61 year old African-American female, was admitted to the Intensive Care Unit (ICU) at University of California, San Diego (UCSD), Medical Center, from June 5, 2003 to July 4, 2003 with multiple medical problems. She had a history of morbid obesity (325 pounds) with some disability. Patient D.D.'s medical records indicate that patient D.D. had been sitting in a chair for two straight days prior to being admitted to the hospital. Her medical records also note that patient D.D.'s skin was intact on admission to the ICU.

11. On June 7, 2003, patient D.D. was placed in a Bariatric bed (adjustable bed for larger, overweight patients).

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12. On June 8, 2003, in the Physician Progress Notes, patient D.D. was diagnosed with Deep Vein Thrombosis.

13. On June 9, 2003, ankle blisters and lower extremity bullae (blisters) were noted in the Physician Progress Notes for patient D.D. Later that day, patient D.D. underwent surgery for incision and drainage of an abscess of the medial left leg, exploratory fasciotomies medial and lateral left leg and aspiration of the ankle joint.

14. On June 10, 2003, from 7:00 p.m. to June 11, 2003 at 7:00 a.m., Respondent took care of patient D.D. while she was in the ICU.

15. On June 11, 2003, the first documentation of a Stage 1 skin tear on patient D.D.'s coccyx was noted on the skin diagram on the Nursing ICU flow sheet. Patient D.D. was assessed as a low risk under the Braden Skin Risk Assessment scale for predicting pressure ulcer risk. An Allevyn dressing was applied at that time.

16. On June 12, 2003, a skin tear on the right buttock was listed as a Stage 2 pressure ulcer on the Nursing ICU flow sheet. That day, patient D.D. was assessed as a high risk using the Braden Skin Risk Assessment scale.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent is subject to disciplinary action under section Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m. on June 10, 2003 to 7:00 a.m. on June 11, 2003, Respondent was incompetent in her care of patient D.D. within the meaning of Regulation 1443, as follows:

18. Respondent failed to develop care plans or follow through with preventative nursing care interventions to follow up on patient D.D.'s Braden Scale Score of 12, which is defined as high risk for developing pressure ulcers, to prevent further skin integrity deterioration.

19. Under the "Equipment" section of the "Shift Assessment," Respondent documented patient D.D. was on a Contoura bed. This bed was not a pressure relieving bed but instead a bariatric bed. Respondent was unfamiliar with the standard of practice for using specialty beds. Respondent lacked knowledge in the specialty bed area because she failed to demonstrate she

understood the difference between a "bariatric bed" and a "specialty bariatric bed." There was a lack of training and lack of information concerning assessment and identification on the use of a specialty bed. This placed patient D.D. at increased risk for the development of pressure ulcers because she did not have pressure relief and she was not turned while in bed, leading to the development of pressure ulcers.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m. on June 10, 2003 to 7:00 a.m. on June 11, 2003, Respondent committed acts constituting negligence in her care of patient D.D. as follows

21. On the ICU flow sheet, under the "Treatment/Procedures" area, under the "Reassessment/Condition section, Respondent left it blank for patient D.D. Below this area, Respondent wrote "bath" and "skn" at 12 midnight. Respondent did not document "pericare" of the patient during her shift. Respondent failed to document that she reassessed the condition of patient D.D. during the shift and did not document all care given on the flow sheet. Respondent's conduct was negligent in her assessing, inspecting and planning to protect patient D.D. from skin breakdown.

22. In the "Shift Assessment" section, in the "Integumentary" section, Respondent documented that patient D.D.'s skin condition and mucous membranes were "warm and dry." Respondent failed to document patient D.D.'s skin integrity and did not document skin assessment on her shift, despite the medical staff documenting concerns about patient D.D.'s edema, circulation and lung volume issues, leg wound drainage, pain, and concerns about infection and dehydration; all factors that contribute to breakdown in skin integrity. Respondent did not make an assessment of the notations on the body chart during her shift and did not document potential or actual skin breakdown. Respondent did not implement or develop skin precautions or interventions.

23. In the "Activity" section under "Treatment/Procedures," Respondent left that area blank. Respondent failed to document turning patient D.D. or demonstrate she turned or inspected the skin of patient D.D. during her shift.

24. In a "Nutrition" note dated June 9, 2003, there was concern over patient D.D.'s low serum albumin level of 1.4, which is considered high risk for skin breakdown. Patient D.D. was also using a rectal bag for incontinence. Respondent failed to follow up and develop a plan of care for patient D.D. to address the potential skin breakdown in her rectal area and posterior buttocks with risk factors of rectal incontinence and a low serum albumin level of 1.4.

25. There was a concern on the previous shift by the RN and by the physicians about problems with patient D.D.'s left hand and wrist with an edema moving up the arm to the elbow. During her shift, under the "Edema" section, Respondent marked patient D.D.'s left upper extremity as "difficult to assess due to immobility." Respondent failed to follow up with any documentation on the condition of patient D.D.'s extremities. Respondent did not develop any plans of care, interventions or show reassessment of the extremity problems that were documented earlier in the day.

26. Respondent documented under the "Problems/Intervention/Patient Outcome" section of the ICU flow sheet that patient D.D.'s left leg dressing was taken down and the Penrose drain was disconnected and the leg redressed. However, Respondent failed to describe the undressed wound, with descriptions of color, size and drainage.

27. Respondent failed to advocate for patient D.D. by failing to obtain pressure relieving bed equipment early during patient D.D.'s hospitalization. Respondent failed to take initiative to minimize patient D.D.'s skin breakdown risk by failing to obtain a specialty bed for her.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 423406, issued to Martha L. Demeyere;

2. Ordering Martha L. Demeyere to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/8/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HAYDEE MADRIGAL** **502 J Street** **Latrhop, CA 95330** **Registered Nurse License No. 601549** Respondent.	Case No. 2010-7 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 8, 2002, the Board of Registered Nursing issued Registered Nurse License Number 601549 to Haydee Madrigal (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
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> (a) Unprofessional conduct, which includes, but is not limited to, the following:
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> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
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> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF FACTS

10. Patient D.D., a 61 year old African-American female, was admitted to the University of California, San Diego (UCSD), Medical Center, Intensive Care Unit (ICU) from June 5, 2003 to July 4, 2003. Patient D.D. was admitted to the ICU with multiple medical problems. She had a history of morbid obesity (325 pounds) with some disability. Patient D.D.'s medical records indicate that patient D.D. had been sitting in a chair for two straight days prior to being admitted to the hospital. Her medical records also note that patient D.D.'s skin was intact on admission to the ICU.

11. On June 7, 2003, patient D.D. was placed in a Bariatric bed (adjustable bed for larger, overweight patients).

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12. On June 8, 2003, in the Physician Progress Notes, patient D.D. was diagnosed with Deep Vein Thrombosis.

13. On June 9, 2003, ankle blisters and lower extremity bullae (blisters) were noted in the Physician Progress Notes for patient D.D. Later that day, patient D.D. underwent surgery for incision and drainage of an abscess of the medial left leg, exploratory fasciotomies medial and lateral left leg and aspiration of the ankle joint.

14. On June 9, 2003, from 7:00 p.m. to June 10, 2003 at 7:00 a.m., Respondent took care of patient D.D. while she was in the ICU.

15. On June 11, 2003, the first documentation of a Stage 1 skin tear on patient D.D.'s coccyx was noted on the skin diagram on the Nursing ICU flow sheet. Patient D.D. was assessed as a low risk under the Braden Skin Risk Assessment scale for predicting pressure ulcer risk. An Allevyn dressing was applied at that time.

16. On June 12, 2003, a skin tear on the right buttock was listed as a Stage 2 pressure ulcer on the Nursing ICU flow sheet. That day, patient D.D. was assessed as a high risk using the Braden Skin Risk Assessment scale.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

17. Respondent is subject to disciplinary action under section Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m. on June 9, 2003 to 7:00 a.m. on June 10, 2003, Respondent was incompetent in her care of patient D.D. within the meaning of Regulation 1443, as follows:

18. Respondent did not initiate a request for a specialty bed to relieve pressure for patient D.D. Respondent failed to carry out her professional nursing obligations to identify when to use a special bed with pressure relief to prevent or prevent further development of skin breakdown on patient D.D., showing a lack of knowledge. Respondent did not indicate that she knew the difference between a "bariatric bed" and a "specialty bariatric bed." On June 9, 2003, patient D.D. was on a bariatric bed, used for obese patients, but not providing pressure relief.

19. Respondent failed to acknowledge patient D.D.'s low serum albumin score and did not institute a plan for care or document the patient's high risk for skin breakdown, even when patient D.D. had surgery for lower extremity skin integrity issues. Respondent was incompetent because she lacked the knowledge or the ability to carry out professional nursing obligations during her shift. Respondent did not assess or use critical thinking skills. Respondent did not formulate plans and interventions for a low serum albumin level, which placed patient D.D. at an increased risk for further skin breakdown.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

20. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on her shift from 7:00 p.m. on June 9, 2003 to 7:00 a.m. on June 10, 2003, Respondent committed acts constituting negligence in her care of patient D.D. as follows:

21. Respondent failed to provide basic skills that provide for the safety, comfort, hygiene and protection of patient D.D. During her shift, Respondent failed to document under "Treatment/Procedures" on the ICU flow sheet, that a bath was given, or that pericare, Foley care or skin care was given to patient D.D. Additionally, in the "Activity" section under "Treatment/Procedures," Respondent left that area blank. Respondent did not enter that patient D.D. was turned or moved during her shift. Under "Pulmonary," Respondent did not document that she listened to or auscultated patient D.D.'s posterior pulmonary area. Respondent did not write in breath sounds posteriorly. Respondent failed to chart anything in the "Skin Integrity" section in patient D.D.'s medical record. Respondent did not mark the body chart on the ICU flow sheet and did not complete the Braden Skin Risk Assessment Scale for patient D.D. during her shift. Respondent failed to plan professional nursing interventions to prevent further skin integrity deterioration based on a totaled Braden Skin Risk Assessment Scale Score for patient D.D.

22. When Respondent charted in the "Shift Assessment" section under "Cardiovascular" for "Edema" in patient D.D.'s medical records, Respondent left the area blank. This section

included the extremity pulses. Respondent did not address or document there were problems with patient D.D.'s dorsalis pedis, even though patient D.D. had many skin integrity issues on her extremities. Respondent did not document nursing physical assessments after patient D.D. was returned to ICU from surgery. Respondent was negligent due to her failure to complete the nursing and skin assessments in the "Cardiovascular," "Integumentary" and "Musculoskeletal" sections of the ICU flow sheet. Respondent exhibited a lack of direct nursing care, lack of observation and lack of assessments. Respondent's lack of documentation and assessments during her shift did not show assessment or acknowledgement of patient D.D.'s risks and medical issues.

23. Respondent was negligent because she displayed a lack of attention to patient D.D.'s elevated temperature pre and post-operative. Prior to patient D.D. leaving for surgery on June 9, 2003, she had an elevated temperature of 101.5, 101.3, 100.7, 99.7 and 101 degrees Fahrenheit. When patient D.D. returned to ICU after surgery at 8:45 p.m., Respondent recorded only one temperature reading for patient D.D. during her shift of 97.5 degrees Fahrenheit at 9:00 p.m. Respondent failed to interpret information or results from the previous shift concerning the surgery or the elevated temperatures before or after the surgery.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 601549, issued to Haydee Madrigal;

2. Ordering Haydee Madrigal to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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3. Taking such other and further action as deemed necessary and proper.

DATED: 7/8/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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